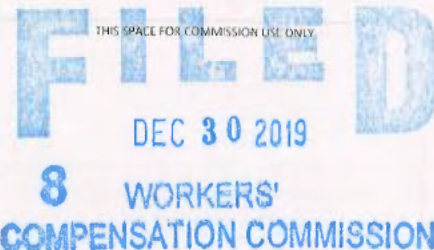


CC-FORM-3USE FOR ACCIDENTAL INJURY OR CUMULATIVE TRAUMA
OCCURRING ON OR AFTER FEBRUARY 1, 2014Send original and 4 copies to:
Workers' Compensation Commission**WORKERS' COMPENSATION COMMISSION**
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

Full Name of Claimant (Injured Employee) Brandon Wichert
Name of Employer Re-View Windows, Inc.
Commission Use Only <i>Argonaut Ins</i>

- ☒ Please check appropriate box
- ☒ I. Original Filing
- ☐ II. Amends Previously Filed CC-Form-3.
(Highlight the change and identify whether it adds to or replaces the prior information.)

EMPLOYEE'S FIRST NOTICE OF CLAIM FOR COMPENSATION

NOTE: Mediation is available to help resolve certain workers' compensation disputes.

For information, call (405) 522-5308 or In-State Toll Free (855) 291-3612.

(Please type or print)

COMMISSION FILE NO. **2019 08128 0**

FULL NAME OF EMPLOYEE (Last, First, Middle): Wichert, Brandon		Social Security Number (LAST 5 DIGITS ONLY): XXX-X 88880		Phone: (405) 938-6125	
Mailing Address (include City, State & Zip): 6712 Bayberry Dr. Okc, OK 73162		Date of Birth: 01/19/1989		Age: 30	Sex: Male
Occupation: Installer	Was your employment agreement in Oklahoma? YES NO	Avg. Weekly Wage: Max	Length of Employment: Years 1 Months		
Date of Accident/Injury 5/15/2019		Injury resulted from: Single Incident <input checked="" type="checkbox"/> Cumulative Trauma		Time Injury Occurred ____ AM ____ PM	
Describe parts of the body injured or affected Jaw, Cheek bone, Eye, Head, Neck, Back, L/Shoulder		Place of injury: City/County/State Nashville, Davidson County, TN			
What is the nature of the Injury or Illness: unknown		Describe with details how the injury occurred. Include object or substance which directly injured you: MVA: clmt was passenger in company vehicle when 3rd party ran light			
Have you filed a claim for Social Security Disability Insurance Benefits? YES NO <input checked="" type="checkbox"/>					
Are you eligible for Medicare Benefits or will you become eligible for Medicare Benefits within 30 months of the filing of this Notice of Claim for Compensation? YES NO <input checked="" type="checkbox"/>					
Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? ____ If so, you may be entitled to benefits for combined disabilities against the Multiple Injury Trust Fund (MITF). A claim against the MITF is commenced by filing a "CC-Form-3F" with the Workers' Compensation Commission.					
Treating Physician (full name):		Address:		City:	State: Zip:
Employer: Re-View Windows, Inc.		Employer's FEI # (Federal ID Number):		Telephone: 816-741-2876	
Complete Mailing Address: 1235 Saline St.		City: N. Kansas City, MO		State: 64116	Zip:
Complete Street Address (if different from above):		City:		State:	Zip:

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

CLAIM INFORMATION (Please Print)Is this a claim for **initial** benefits (i.e. no benefits, either medical or indemnity, have been received)? YES ☒ NOIs this a claim for **additional** benefits (e.g. additional temporary total disability, additional medical)? ☒ YES NO

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form:

Name of claimant's attorney if represented:

Type or Print Name of Attorney: Charles T. Simons	OBA# 17762
Mailing Address: 4323 N.W. 63rd St., #110	
City Oklahoma City	State Zip OK 73116
Telephone #: (405) 528-4567	

NOTICE: Pursuant to 85A O.S. §118, a fee of One Hundred Forty Dollars (\$140.00) shall be collected by the Workers' Compensation Commission and assessed as costs to be paid by the party against whom any award becomes final.

The undersigned declare under PENALTY OF PERJURY that they have examined this *Employee's First Notice of Claim for Compensation*, and all statements contained herein are true, correct and complete, to the best of their knowledge and belief.

Signed this **27th** day of **December**, 2019

Signature of Claimant (must be signed by Claimant)

Signature of Attorney for Claimant (if any)